303 837 DENTAL

303.1 GENERAL INFORMATION

Introduction

This chapter contains information on processing electronic claims based on the 004010X097 version of the ASC X12N Dental Health Care Claim (837D) Implementation Guide and the Addenda (004010X097A1) dated October 2002. This document will identify information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services (HFS).

303.2 TECHNICAL INFORMATION

This section contains information relating to transmitting information to the Department. Additionally, this section will identify, down to the data element level, anything unique to the Department in regards to the X12 EDI transaction.

Transmission Information

The Department will continue to support a means by which its Dental Administrator transmits and receives electronic data.

X12 EDI Information

The Department has identified, down to the data element level, anything unique to our processing requirements in regards to the various EDI transactions. This document will identify only those things that the Department requires that are not clearly identified in the Implementation Guide.

Billing Note

The **Subscriber** is always the **Patient**. Claim information should be placed at the subscriber hierarchical level. Claims with information in the Patient hierarchical level will not be accepted into our processing system.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
56		Beginning of Hierarchical Transaction	BHT06	Transaction Type Code	Must be “CH”.
60	1000A	Submitter Name	NM102	Entity Type Qualifier	Must be “2”.
61	1000A	Submitter Name	NM109	Identification Code	Must be the Dental Administrator’s Federal Tax Identification Number.
67	1000B	Receiver Name	NM102	Entity Type Qualifier	Must be “2”.
67	1000B	Receiver Name	NM103	Organization Name	Must be "ILLINOIS MEDICAID”
67	1000B	Receiver Name	NM109	Identification Code	Must be "37-1320188".
71	2000A	Billing/Pay to Provider Specialty Information	PRV01	Provider Code	Must be "BI".
77	2010AA	Billing Provider Name	NM103	Name Last or Organization Name	Must be the Provider's Last name or Provider’s Organization name exactly as it is shown on IHFS's Provider Information Sheet.
77	2010AA	Billing Provider Name	NM104	Name First	If NM102 = “1”, must be the First Name of the Provider and exactly as it appears on the Provider Information Sheet. If NM102 = “2”, must be spaces.
77	2010AA	Billing Provider Name	NM105	Name Middle	If NM102 = “1”, must be the Middle Name of the Provider and exactly as it appears on the Provider Information Sheet. If NM102 = “2”, must be spaces.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
77	2010AA	Billing Provider Name	NM107	Name Suffix	If NM102 = “1”, must be the Name Suffix of the Provider and exactly as it appears on the Provider Information Sheet. If NM102 = “2”, must be spaces.
84	2010AA	Billing Provider Secondary Identification Number	REF01	Reference Identification Qualifier	Must be "1D".
84	2010AA	Billing Provider Secondary Identification Number	REF02	Reference Identification	Must be the nine, ten, or twelve-digit IHFS Provider number as shown on the Provider Information Sheet.
88	2010AB	Pay to Provider’s Name	NM103	Last Name or Organization Name	Must be Doral Dental Services of Illinois.
95	2010AB	Pay-To Provider Secondary Identification Number	REF01	Reference Identification Qualifier	Must be "1D”.
95	2010AB	Pay-To Provider Secondary Identification Number	REF02	Reference Identification	Must be Doral’s 1-digit payee number: “8”.
97	2000B	Subscriber Hierarchical Level	HL04	Hierarchical Level Code	Must be “0”.
101	2000B	Subscriber Information	SBR09	Claim Filing Indicator Code	Must be “MC”.
104	2010BA	Subscriber Name	NM102	Entity Type Qualifier	Must be “1”.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
104	2010BA	Subscriber Name	NM103	Name Last or Organization Name	Must be the Last Name of the Recipient and exactly as it appears on the MediPlan Card, KidCare Card or SeniorCare Card.
104	2010BA	Subscriber Name	NM104	Name First	Must be the First Name of the Recipient and exactly as it appears on the MediPlan Card, KidCare Card or SeniorCare Card.
104	2010BA	Subscriber Name	NM105	Name Middle	Must be the Middle Name of the Recipient and exactly as it appears on the MediPlan Card, KidCare Card or SeniorCare Card.
105	2010BA	Subscriber Name	NM107	Name Suffix	Must be the Name Suffix of the Recipient and exactly as it appears on the MediPlan Card, KidCare Card or SeniorCare Card.
105	2010BA	Subscriber Name	NM108	Identification Code Qualifier	Must be “MI”.
106	2010BA	Subscriber Name	NM109	Identification Code	Must be the Recipient's 9-digit number as it is shown on the MediPlan Card, KidCare Card or SeniorCare Card.
118	2010BB	Payer Name	NM103	Name Last or Organization Name	Must be "ILLINOIS MEDICAID”.
118	2010BB	Payer Name	NM108	Identification Code Qualifier	Must be “PI”.
118	2010BB	Payer Name	NM109	Identification Code	Must be "37-1320188".
150	2300	Claim Information	CLM01	Claim Submitter’s Identifier	1st 14-bytes must be the Provider Reference Number.
151	2300	Claim Information	CLM02	Monetary Amount	The amount reported here must equal the total of all of the SV302 amount(s).

IG Page #	Loop	Description	Element ID	Element Name	Remarks
151	2300	Claim Information	CLM05-03	Claim Frequency Type Code	Must be “1”, “7”, or “8”.
152	2300	Claim Information	CLM06	Yes/No Condition or Response Code	Must be “Y”.
173	2300	Patient Amount Paid	AMT02	Monetary Amount	If the Subscriber owes a spenddown, you must use this element to report the amount. DPA Form 2432 "Split Billing Transmittal Form" must also be submitted. DO NOT report the "patient credit" amount on the 837 as the Department is already automatically deducting it.
180	2300	Original Reference Number (ICN/DCN)	REF02	Reference Identification	When attempting to void/replace a previously submitted claim, if the provider submits a 15-digit DCN in the Original ICN/DCN REF, the entire DCN will be voided/replaced. If the provider submits the 15-digit DCN followed by a 2-digit service section (17-digit DCN, total) only that service section from the original claim will be voided/replaced.
186	2300	Claim Note	NTE02	Description	Must be the “Claim Receipt Date”, “Adjudication Date”, “Paid Date”, separated by dashes. Must be left justified in CCYYMMDD format.
201	2310B	Rendering Provider Secondary Identification	REF01	Reference Identification Qualifier	For RHC or FQHC, must be “1D”.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
202	2310B	Rendering Provider Secondary Identification	REF02	Reference Identification	If REF01 = “1D”, then this must be the 9, 10, or 12-digit IHFS Provider Number of Dentist providing the service.
247	2330B	Other Payer Secondary Identifier	REF01	Reference Identification Qualifier	Must be "2U".
248	2330B	Other Payer Secondary Identifier	REF02	Reference Identification	Must be the claim level 3-digit TPL code followed by the 2-digit status code assigned by HFS to Other Payers. For other TPL codes, please reference Appendix 9 in Chapter 100. For Status Codes, see Appendix 17 in Chapter 200, Handbook for Hospitals.